The Joint Commission

Cherry Hospital
201 Stevens Mill Road
Goldsboro, NC 27530

Organization Identification Number: 3082

Date(s) of Survey: 10/1/2008 - 10/2/2008

PROGRAM(S)
Hospital Accreditation Program

SURVEYOR(S)
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Executive Summary

Based on the accreditation survey, your organization has met criteria that may result in Conditional Accreditation. The survey findings will be reviewed in The Joint Commission's Central Office. If, as a result of this review, your organization continues to meet the criteria for Conditional Accreditation, the survey findings will be posted to your secure extranet site and your organization will have 10 business days to submit clarifying Evidence of Standards Compliance (ESC), for any standards that you believe you were compliant with at the time of survey. Should the central office review of your clarifying Evidence of Standards Compliance result in your organization continuing to meet the criteria for Conditional Accreditation, the survey findings will be presented to the Accreditation Committee for a decision. Should the central office review of your clarifying Evidence of Standards Compliance result in your organization no longer meeting criteria for Conditional Accreditation, an on-site Clarification Validation Survey (CVS) will occur. This survey will be performed by a member of our Standards Interpretation staff within 5 days of the completion of our review of the clarifying ESC. Your Account Representative will contact you regarding this process.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

The Joint Commission
Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Communication

Standard: LD.2.20

Program: HAP

Standard Text: Each organizational program, service, site, or department has effective leadership.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. The program, service, site, or department leaders ensure that operations are effective and efficient.

Scoring Category : B
5. Leaders ensure that a process is in place to coordinate care, treatment, and service processes among programs, services, sites, or departments.

Surveyor Findings

EP 1
Observed in Tracers at Cherry Hospital site.
There is a lack of efficient effective services as demonstrated during patient and system tracers. A turnaround time for the reporting of cardiac enzymes was inefficient. The failure to identify outdated reagents for quality control demonstrated lack of effective oversite. The failure to comply with current acceptable practice and regulations in the disposal of waste was not effective or efficient.

EP 5
Observed in Patient and system tracers at Cherry Hospital site.
Leaders failed to coordinate care treatment and services as described in LD.1.20.
Governance failed to provide for integration of care as observed during a patient tracer on the geriatric unit. A practitioner ordered cardiac enzymes on a patient who was having chest pain. The phlebotomist who was supervised and trained by the nursing staff drew blood and sent it to the lab. It was drawn in the wrong tube had had to be redrawn. It took six hours to turn around the report from the time of the order to the time of the report back to the nurse on the unit. The early identification of elevated cardiac enzymes is critical in most facilities. The process demonstrated the lack of coordination among the medical staff, the nursing staff, and the laboratory.
The practitioner should have known what specific test to order, The nursing staff should have provided appropriate training to the phlebotomist. The director of the laboratory should have communicated effectively with both the medical staff and the nursing staff.
Governance failed to provide for integration of care as observed during a patient tracer on the geriatric unit. A practitioner ordered cardiac enzymes on a patient who was having chest pain. The phlebotomist who was supervised and trained by the nursing staff drew blood and sent it to the lab. It was drawn in the wrong tube had had to be redrawn. It took six hours to turn around the report from the time of the order to the time of the report back to the nurse on the unit. The early identification of elevated cardiac enzymes is critical in most facilities. The process demonstrated the lack of coordination among the medical staff, the nursing staff, and the laboratory.
The practitioner should have known what specific test to order, The nursing staff should have provided appropriate training to the phlebotomist. The director of the laboratory should have communicated effectively with both the medical staff and the nursing staff.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Communication

Standard: LD.3.60

Program: HAP

Standard Text: Communication is effective throughout the hospital.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. The leaders ensure processes are in place for communicating relevant information throughout the organization in a timely manner.

Scoring Category : B
2. Effective communication occurs in the organization, among the organization's programs, among related organizations, with outside organizations, and with patients and families, as appropriate.

Surveyor Findings

EP 1
Observed in tracers at Cherry Hospital site.
Communication is not effective as demonstrated by the long turnaround time for the reporting of cardiac enzymes because the phlebotomist was not told what enzyme was to be drawn or what tube in which to draw the enzyme.

Observed in EC tracers at Cherry Hospital site.
Communication is ineffective as demonstrated by the failure to recognize and report the methods of disposal of possibly infectious waste.

Observed in tracer at Cherry Hospital site.
Communication is ineffective as demonstrated by the lack of identifying and reporting outdated reagents used in the quality control of the waived tests,

EP 2
Observed in system and patient tracers at Cherry Hospital site.
Communication is ineffective as demonstrated by the absence of effective communication among the various departments and services responsible for the management of potentially infectious waste.

Observed in tracer at Cherry Hospital site.
Communication was ineffective as demonstrated by the lack of effective communication among those responsible for ordering, those responsible for drawing, and those responsible for processing laboratory tests.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Credentialed Practitioners

Standard: MS.4.10

Program: HAP

Standard Text: The hospital collects information regarding each practitioner's current license status, training, experience, competence and ability to perform the requested privilege.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
6. The credentialing process requires that the organization verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information:

The applicant's current licensure at time of initial granting, renewal, and revision of privileges, and at the time of license expiration
The applicant's relevant training
The applicant's current competence

Surveyor Findings

EP 6
Observed in Interviews and documents at Cherry Hospital site.
In an interview with the CEO and clinical director, addressing contract services, it was noted that there were a number of contracts with free standing outpatient programs, not joint commission accredited, for care and treatment of patients. For example orthopedic care and nephrology care. Physicians providing care off site were not credentialed by the medical staff and the license and training had not been verified form primary source.

Standard: MS.4.15

Program: HAP

Standard Text: The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidenced-based process.

Secondary Priority Focus Area(s): Information Management, Organizational Structure

Element(s) of Performance

Requirement(s) for Improvement

Scoring Category : B
1. The organization, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of the following are included in the criteria:

Current licensure and/or certification, as appropriate, verified with the primary source.

The applicant's specific relevant training, verified with the primary source.

Evidence of physical ability to perform the requested privilege*.

Data from professional practice review by an organization(s) that currently privileges the applicant (if available).

Peer and/or faculty recommendation.

When renewing privileges, review of the practitioner's performance within the organization.

*Organizations should consider the applicability of the Americans with Disabilities Act (ADA) to their credentialing and privileging activities, and, if applicable, review their medical staff bylaws, policies, and procedures. Federal entities are required to comply with the Rehabilitation Act of 1974.

Scoring Category : B
2. Each of the criteria used are consistently evaluated for all practitioners holding that privilege.

Scoring Category : A
6. The organization queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

Surveyor Findings

EP 1
Observed in credentialing at Cherry Hospital site.
In an interview with the CEO and clinical director, addressing contract services, it was noted that there were a number of contracts with free standing outpatient programs, not joint commission accredited, for care and treatment of patients. (For example orthopedic care and nephrology care.) Physicians providing care off site were not credentialed by the medical staff and the license and training had not been verified form primary source. Peer review, practice monitoring, and performance review are not addressed for those practitioners

EP 2
Observed in credentialing at Cherry Hospital site.
The criteria are not used in reviewing each practitioner providing services. In an interview with the CEO and clinical director, addressing contract services, it was noted that there were a number of contracts with free standing outpatient programs, not joint commission accredited, for care and treatment of patients. For example orthopedic care and nephrology care. Physicians providing care off site were not credentialed by the medical staff and the license and training had not been verified form primary source.

EP 6
Observed in credentials and contract review at Cherry Hospital site.
National practitioner data back was not queried for all practitioners who provide service to the patients. In an interview with the CEO and clinical director, addressing contract services, it was noted that there were a number of contracts with free standing outpatient programs, not joint commission accredited, for care and treatment of patients. For example orthopedic care and nephrology care. Physicians providing care off site were not credentialed by the medical staff and the license and training had not been verified form primary source.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Infection Control

Standard: IC.3.10

Program: HAP

Standard Text: Based on risks, the hospital establishes priorities and sets goals for preventing the development of health care-associated infections within the hospital.

Secondary Priority Focus Area(s): Organizational Structure

Element(s) of Performance

Scoring Category : A
2. These goals include, but are not limited to, the following: Limiting unprotected exposure to pathogens throughout the organization

Surveyor Findings

EP 2
Observed in tracer activity at Cherry Hospital site.
Potentially infectious waste was not separated from other waste after it was placed in the red bags which were disposed of in the land fill.

Observed in Tracer activity at Cherry Hospital site.
As confirmed by interviews and review of policy, the nursing service disposed of potential infectious waste with regular waste by sending it to the land fill. this is not the appropriate.

Standard: IC.5.10

Program: HAP

Standard Text: The infection control program evaluates the effectiveness of the infection control interventions and, as necessary, redesigns the infection control interventions.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. The organization formally evaluates and revises the goals and program (or portions of the program) at least annually and whenever risks significantly change.

Surveyor Findings

EP 1
Observed in infection control at Cherry Hospital site.
There was no formal evaluation of the infection control program to indicate that the program had been evaluated in 2007. The infection control policies and procedures had not been revised since 2002.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Medication Management

Standard: MM.7.10

Program: HAP

Standard Text: The hospital develops processes for managing high-risk or high-alert medications.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
2. Based on the services provided, the organization develops processes for procuring, storing, ordering, transcribing, preparing, dispensing, administering, and/or monitoring high-risk or high-alert medications.

Surveyor Findings

EP 2
Observed in documents and interviews at Cherry Hospital site.
During a patient tracer it was noted that more than one type of insulin was stored in the same bin in the refrigerator. For the high-risk high-alert medications there were no written procedures addressing addressing procuring, storing, ordering, administering and monitoring.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: EC.5.50

Program: HAP

Standard Text: The hospital develops and implements activities to protect occupants during periods when a building does not meet the applicable provisions of the Life Safety Code®.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
3. Each organization implements ILSMs as defined in its policy.

Surveyor Findings

EP 3
Observed in document review at Cherry Hospital site.
During the document review it was observed that the hospital did not implement ILSM according to their policy during the installation of new Fire Alarm devices.
On Sept. 29 at 0830am disable various fire alarm devices in the U 2 Building to install the new devices. The fire alarm system was not put back to normal operation until 0800am of Oct. 1. This was verified by a print out of the history of the fire alarm system. During the time the devices was disabled no ILSM were completed.
Also per their ILSM policy a fire watch should have been completed in additions to ILSM and no fire watch was completed at this time.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: EC.8.10

Program: HAP

Standard Text: The hospital establishes and maintains an appropriate environment.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
4. Areas used by the patients are safe, clean, functional, and comfortable.

Surveyor Findings

EP 4
Observed in adolescent units at Cherry Hospital site.
There were drop ceilings in each of the adolescent units above which patients could hide contraband and could use to find pipes or conduits over which they could hand themselves.

Observed in Adolescent units at Cherry Hospital site.
There was open plumbing in the toilets on the adolescent unit.

Observed in U2 - 3 East Unit at Cherry Hospital site.
During tracer activities, observations were made that there were unsafe items throughout the unit that could allow an individual to cause self-harm. There was a long hand held shower hose, a vent in the ceiling with open grill work in the shower room and water facucets in the showers that could have the potential for self harm. The hinges on the doors of the wardrobes in the room were the type that an individual could loop something over the top hinge and cause self harm.

Observed in during the building tour at Cherry Hospital site.
During the building tour it was observed that the building U2 the East Side elevator emergency alarm was too low and staff could not here it to respond in an emergency.

Observed in building tour at Cherry Hospital site.
During the building tour it was observed that in building U2 the West Side elevators the emergency alarm did not work at all.

Observed in during the building tour at Cherry Hospital site.
During the building tour it was observed that in Building U1 the elevator on the 1st floor East side the emergency alarm works but staff dose not respond because they can not here it because a no staff member is near the elevator and all corridor doors are closed.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: NPSG Requirement 16A

Program: HAP

Standard Text: The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
3. As of October 1, 2008, pilot testing in at least one clinical unit is under way.

Surveyor Findings

EP 3
Observed in document review at Cherry Hospital site.
The organization had not developed a plan or had they began to start pilot testing a process to improve recognition and response to changes in a patient's condition.

Standard: NPSG Requirement 2C

Program: HAP

Standard Text: Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical tests and critical results and values.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. The organization defines critical tests and critical results and values.

Scoring Category : A
5. The organization assesses the data and determines whether there is a need for improvement.

Surveyor Findings

EP 1
Observed in data review at Cherry Hospital site.
The organization had not identified critical tests and results for radiology and EKGs.

EP 5
Observed in document reviews at Cherry Hospital site.
The organization had not collected data on the timeliness of reporting critical radiology and EKG tests and results.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: NPSG Requirement 3C

Program: HAP

Standard Text: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
3. The organization takes action to prevent errors involving the interchange of these drugs.

Surveyor Findings

EP 3
Observed in documents and interviews at Cherry Hospital site.
There were no written documents addressing procedures to prevent errors related to look-alike/sound-alike drugs.

Standard: NPSG Requirement 3E

Program: HAP

Standard Text: Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

Note: This requirement applies only to organizations that provide anticoagulation therapy.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
3. As of October 1, 2008, pilot testing in at least one clinical unit is under way.

Surveyor Findings

EP 3
Observed in interviews and documents at Cherry Hospital site.
The facility had not implemented the draft plan as a pilot.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: PC.12.10

Program: HAP

Standard Text: The leaders establish and communicate the hospital's philosophy on restraint and seclusion to all staff with direct care responsibility.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. At a minimum, the organization's philosophy addresses the following:

Its commitment to prevent, reduce, and strive to eliminate restraint and seclusion
Prevention of emergencies that have the potential to lead to use of restraint or seclusion
Non-physical interventions as preferred interventions
Limitation of the use of restraint and seclusion to emergencies in which there is an imminent risk of a patient physically harming himself or herself or others, including staff
Its responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible
Raising awareness among staff about how restraint or seclusion may be experienced by the patient
Preserving the patient's safety and dignity when restraint or seclusion is used

Surveyor Findings

EP 1
Observed in patient tracer at Cherry Hospital site.
During a patient tracer on the adolescent unit, staff described the process for NCI hold which included taking the patient to the floor and having two HCT each place a knee on the patient's shoulder. Also described was the use of a basket hold. Both of these procedures present some risk of asphyxiation of the patient, particularly a child.

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Physical Environment

Standard: EC.5.20

Program: HAP

Standard Text: Newly constructed and existing environments are designed and maintained to comply with the Life Safety Code®.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
1. Each building in which patients are housed or receive care, treatment, and services complies with the LSC, NFPA 101® 2000; OREach building in which patients are housed or receive care, treatment, and services does not comply with the LSC, but the resolution of all deficiencies is evidenced through the following:

An equivalency approved by the Joint Commission Or

Continued progress in completing an acceptable Plan For Improvement (Statement of Conditions™, Part 4)

Surveyor Findings

Please see life safety code report.

Requirement: EC.A.1H

Phrase: Existing Health Care Occupancies When the following penetrate fire resistance rated wall assemblies, the spaces between the item and the wall are filled with an appropriate fire resistance rated material: pipes, conduits, bus ducts, cables/wires, air ducts and pneumatic tubes. (EC.A.1H)

During the building tour it was observed that in the following locations the fire wall assemblies had penetration that were not properly sealed:
1. In the exit stairwell 2nd floor center of building U1
2. In the exit stairwell 3rd floor West of building U1

Requirement: EC.A.3C.1

Phrase: Existing Health Care Occupancies Smoke barriers are: continuous from outside wall to outside wall. (EC.A.3C)(EC.A.3C.1)

During the building tour it was observed that in the following Non-Sprinkled locations the smoke wall assemblies had penetration that were not properly sealed:
1. 1st floor West Dining room of building U2
2. 3rd floor West above door 304 in Building U2
3. 3rd floor above door 344 in building U1
4. 3rd floor above door 304 in building U1

Requirement: EC.A.3D.2

Phrase: Existing Health Care Occupancies Doors in smoke barriers are: at least 1 3/4-inch solid bonded wood core or equivalent. (EC.A.3D)(EC.A.3D.2)

During the building tour it was observed that the following smoke doors in a non sprinkled building did not have the require rating label attached:
1. Building U2 3rd floor 3 East
2. Building U1 1st floor 1 East
3. Building U1 2nd floor 2 East

Life Safety Code

Inpatient Occupancy Existing Healthcare Occupancies; Section V - Exits

Requirement: EC.A.5J.1

Phrase: Existing Health Care Occupancies Doors in a means of egress: are always unlocked in the direction of egress. (EC.A.5J)(EC.A.5J.1)

All patient room doors have a key lock on the hallway side of the door, which is used to lock the patients out of their room during the day. When a door is locked anyone left in the room has no means of exiting the room. The door knob on the inside will not automatically unlock to allow egress in case of an emergency.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Communication

Standard: LD.1.20

Program: HAP

Standard Text: Governance responsibilities are defined in writing, as applicable.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
6. Governance provides for coordination and integration among the organization's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

Surveyor Findings

EP 6
Observed in Environment of care at Cherry Hospital site.
The governance process did not provide for the safe, effective handling of infectious waste because it deligated the responsibility to several different individuals without provision of appropriate coordination. These individuals included the director of housekeeping, the director of operations, the director of the laboratory, the pharmacist, the infection control officer, the director of nursing, etc . As a result the infection control coordinator produced at policy which was followed by nursing and housekeeping which failed to conform to current practice and regulations. Policies and procedures had been established in 2002 and had not been revised to reflect current expectations

Observed in Patient tracer at Cherry Hospital site.
Governance failed to provide for integration of care as observed during a patient tracer on the geriatric unit. A practitioner ordered cardiac enzymes on a patient who was having chest pain. The phlebotomist who was supervised and trained by the nursing staff drew blood and sent it to the lab. It was drawn in the wrong tube had had to be redrawn. It took six hours to turn around the report from the time of the order to the time of the report back to the nurse on the unit. The early identification of elevated cardiac enzymes is critical in most facilities. The process demonstrated the lack of coordination among the medical staff, the nursing staff, and the laboratory.
The practitioner should have known what specific test to order, The nursing staff should have provided appropriate training to the phlebotomist. The director of the laboratory should have communicated effectively with both the medical staff and the nursing staff.

Supplemental Findings

Standard: PC.16.40

Program: HAP

Standard Text: Policies and procedures governing specific testing-related processes are current, approved, and readily available.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
5. Written policies, procedures, and manufacturer's instructions are followed.

Surveyor Findings

EP 5
Observed in Geriatric unit at Cherry Hospital site.
There were vials of quality control solutions in the unit which had been opened June 17 and were to have been disposed of after 90 days.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Credentialed Practitioners

Standard: MS.4.20

Program: HAP

Standard Text: The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
2. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege.

Surveyor Findings

EP 2
Observed in credentialing and contract review at Cherry Hospital site.
In an interview with the CEO and clinical director, addressing contract services, it was noted that there were a number of contracts with free standing outpatient programs, not joint commission accredited, for care and treatment of patients. For example orthopedic care and nephrology care. Physicians providing care off site were not credentialed by the medical staff and the license and training had not been verified form primary source.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Infection Control

Standard: IC.2.10

Program: HAP

Standard Text: The infection control program identifies risks for the acquisition and transmission of infectious agents on an ongoing basis.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
3. Surveillance activities, including data collection and analysis, are used to identify infection prevention and control risks pertaining to the following:

Patients
Licensed independent practitioners, staff, volunteers, and student/trainees
Visitors and families, as warranted

Surveyor Findings

EP 3
Observed in infection control at Cherry Hospital site.
Surveillance activities including data collection was not analyzed so that the information could be used to identify trends and control risks that would be facility wide to include patients, staff and visitors.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Information Management

Standard: IM.6.20

Program: HAP

Standard Text: Records contain patient-specific information, as appropriate to the care, treatment, and services provided.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
1. Medical records contain, as applicable, the following clinical/case information:

Emergency care, treatment, and services provided to the patient before his or her arrival, if any
Documentation and findings of assessments*
Conclusions or impressions drawn from medical history and physical examination
Diagnosis, diagnostic impression, or conditions
Reason(s) for admission or care, treatment, and services
Goals of the treatment and treatment plan
Diagnostic and therapeutic orders
Diagnostic and therapeutic procedures, tests, and results
Progress notes made by authorized individuals
Reassessments and plan of care revisions
Relevant observations
Response to care, treatment, and services provided
Consultation reports
Allergies to foods and medicines
Medications ordered or prescribed
Dosages of medications administered (including the strength, dose, or rate of administration), administration devices used, access site or route, known drug allergies, and adverse drug reactions
Medications dispensed or prescribed on discharge
Relevant diagnoses/conditions established during the course of care, treatment, and services
* See the “Provision of Care, Treatment, and Services ” chapter in this manual.

Surveyor Findings

EP 1
Observed in medical record at Cherry Hospital site.
Medical record of one patient failed to document the adverse drug reaction as required.

Observed in medical record at Cherry Hospital site.
a second record reviewed failed to document the adverse drug reaction in the discharge summary.

Supplemental Findings

Standard: MM.5.10

Program: HAP

Standard Text: Medications are safely and accurately administered.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
4. Before administering a medication, the licensed independent practitioner or qualified individual administering the medication does the following: Verifies that there is no contraindication for administering the medication.

Surveyor Findings

EP 4
Observed in medical record at Cherry Hospital site.
In one of the records reviewed of a patient who had an adverse drug reaction the MAR and order sheet failed to identify the medication responsible for the ADR. In such condition the person reviewing the order could not identify a contra indication.

Observed in another medical record at Cherry Hospital site.
In another record reviewed the MAR and order sheet failed to identify an ADR which had occurred.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Organizational Structure

Standard: IC.7.10

Program: HAP

Standard Text: The infection control program is managed effectively.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
3. This individual(s) coordinates all infection prevention and control activities within the organization.

Surveyor Findings

EP 3
Observed in infection control at Cherry Hospital site.
During survey the infection control practitioner was reported to have been on vacation. The organization had not identified an individual to assume the responsibility for infection control in the absence of the designated infection control practitioner.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Quality Improvement Expertise/Activities

Standard: LD.3.50

Program: HAP

Standard Text: Care, treatment, and services provided through contractual agreement are provided safely and effectively.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : B
6. Leaders monitor contracted services by evaluating the contracted services in relation to the expectations.

Surveyor Findings

EP 6
Observed in documents and interviews at Cherry Hospital site.
At the time of the survey no data based on operationally defined performance criteria were available for the contract for hemodialysis services which were provided under contract.

Supplemental Findings

These are the Supplemental Findings related to the Primary Priority Focus Area of:

Rights & Ethics

Standard: RI.2.130

Program: HAP

Standard Text: The hospital respects the needs of patients for confidentiality, privacy, and security.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
2. The organization respects the privacy of patients.

Surveyor Findings

EP 2
Observed in U2 - 2 East Unit at Cherry Hospital site.
Several patient rooms were two or four bed wards that did not provide the patients with any privacy that would allow them to change their clothes without other patients observing them.

Observed in U2 - 3 East Unit at Cherry Hospital site.
Several patient rooms were two or four bed wards that did not provide the patients with any privacy that would allow them to change their clothes without other patients observing them.